# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6963

# CERTIFICATE OF DEATH

06935 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 39 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 24
d. STREET ADDRESS: 811 Giles 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: J. — Last: Cunsalvish

4. DATE OF DEATH: Month: 6 — Day: 11 — Year: 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/9/1883

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Engineer Penn. R.R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel Cunsalvish

14. MOTHER'S MAIDEN NAME: Mary Loft

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Frances Cunsalvish — Address: 811 Giles St. Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH

4209

DUE TO (b): Arteriosclerotic Heart Disease — Past 8 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 19 60, to June 11, 19 60, that I last saw the deceased alive on June 11, 19 60, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. J. Simon M.D. ADDRESS (Street, city or town, state): Havre de Grace, Md. DATE SIGNED: 6/14

PHYSICIAN'S NAME (Type): E. J. SIMON

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 6/14/60

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

22d. LOCATION (City, town, or county): Washington (State) D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: JUN 16 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6966 06936

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harre-de-Grace
c. LENGTH OF STAY IN 1b: Two Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit — OTX-2
d. STREET ADDRESS: R.F.D. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry — Middle — Last Baker.

4. DATE OF DEATH: Month 6 — Day 20 — Year 1960

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Dec.31,1875 — 9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Tenant Farmer
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Baker
14. MOTHER'S MAIDEN NAME: Leah Jackson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-18-3554
17. INFORMANT: W. H. Baker — Address: 442 Ottawa ST SW, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Short
DUE TO (b): Chronic Myocarditis — 8yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arterio-Sclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from May 8 1960 to June 20 1960 that (I) (we) last saw the deceased alive on June 20 1960 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Clarence I. Benson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: June 21-1960
22c. PHYSICIAN'S NAME (Type): Clarence I. Benson, M.D.
22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-23-19 60
23c. NAME OF CEMETERY OR CREMATORY: Asbury
23d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE: Lee a. Patterson & Son, — ADDRESS: Perryville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6967

06937

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 30 MIN
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 HAVRE DE GRACE
d. STREET ADDRESS: 715 PULASKI HWY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ALBERT Middle — Last BLUMBERG

4. DATE OF DEATH: Month JUNE Day 7 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WH.
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 19, 1918
9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSURANCE AGENT
10b. KIND OF BUSINESS OR INDUSTRY: INSURANCE
11. BIRTHPLACE (State or foreign country): OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY BLUMBERG
14. MOTHER'S MAIDEN NAME: BESSIE ISREAL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: DR WOLBERT. Address: H.d. Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Acute Pulmonary Oedema | 10 minutes |
| DUE TO (b) | Coronary occlusion - | 5 minutes |
| DUE TO (c) | Angina Pectoris. | |

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1958 to June 7 1960, that (I) (we) last saw the deceased alive on June 7 1960, and that death occurred at 2 P M, from the causes and on the date stated above.

22a. SIGNATURE: Frank Wolbert M D M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 7 1960
22c. PHYSICIAN'S NAME (Type): FRANK WOLBERT M D
22d. ADDRESS: Havre de Grace Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/8/60
23c. NAME OF CEMETERY OR CREMATORY: MISHKIN ISRAEL CONG.
23d. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: SOL LEVINSON & BROS INC. 6010 Reisterstown Rd.
25a. REC'D BY REGISTRAR DATE JUN 10 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# 6958 CERTIFICATE OF DEATH

06938 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 103 Edmund Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 103 Edmund Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDNA Middle WALTER Last BUDNICK

4. DATE OF DEATH: Month June Doy 26 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 29, 1878
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oliver Walter
14. MOTHER'S MAIDEN NAME: Catherine Scarborough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: F. Hollis Budnick Address 442 Wyn-Mar Aberdeen, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Terminal
DUE TO
(b): Arteriosclerotic Heart Disease — 6 mos.
DUE TO
(c): Coronary Arteriosclerosis — 6 mos.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 420-1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6- 19 60, to 6-26- 19 60, that I last saw the deceased alive on 6-29- 19 60, and that death occurred at 9:10 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman, M.D. ADDRESS (Street, city or town, state): Aberdeen, Md DATE SIGNED: June 27 1960

PHYSICIAN'S NAME (Type): Peter P. Rodman M.D. Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/29/60
22c. NAME OF CEMETERY OR CREMATORY: St. Paul Luthern Cem.
22d. LOCATION (City, town, or county) (State): R.D. Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Tarring ADDRESS: Tarring Funeral Home Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: JUN 30 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66939

6987

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shawsville
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Jarrettsville
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Herbert — Last: Cairnes

4. DATE OF DEATH: Month: June — Day: 18 — Year: 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 23, 1885

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Director & Agent

10b. KIND OF BUSINESS OR INDUSTRY: Mutual Insurance Co.

11. BIRTHPLACE (State or foreign country): Jarrettsville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Andrew Cairnes

14. MOTHER'S MAIDEN NAME: Cornealia Haile

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 218-32-3721

17. INFORMANT: Mrs. Louise Cairnes — Address: Jarrettsville Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: immediate
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive Arteriosclerotic Cardiovascular Disease — years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): no accident or injury

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) (County) (State): none

21. I certify that I attended the deceased from Sept. 2, 1959, to June 18, 1960, that I last saw the deceased alive on June 6, 1960, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James F. White, Jr. M.D. — ADDRESS (Street, city or town, state): Houcks Mill Road — DATE SIGNED: June 18, 1960

PHYSICIAN'S NAME (Type): James F. White, Jr. M.D. — Jarrettsville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/21/1960

22c. NAME OF CEMETERY OR CREMATORY: Bethel

22d. LOCATION (City, town, or county) (State): Madonna Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz — ADDRESS: Jarrettsville Md

24a. REC'D BY REGISTRAR — DATE: JUN 21 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06940

6988

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: Lifetime

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air 32
d. STREET ADDRESS: Thomas Run Road + Kalmia Rd
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Thomas Run Road + Kalmia Road

3. NAME OF DECEASED (Type or print): First: Anthony — Middle: C. — Last: Clarke

4. DATE OF DEATH: Month: June — Day: 16 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 19, 1957

9. AGE (In years last birthday): 3 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William L. Clarke Jr.

14. MOTHER'S MAIDEN NAME: Norma Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: William L. Clarke Jr. Address: RD#1, Box 393, Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

929.8

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell into farm pond

20c. TIME OF INJURY: Hour 4 o. m. — Month, Day, Year: 6-16 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm pond

20f. (City or town) Bel Air (County) Ha. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald E Palmer M.D.
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Bel Air, Md
DATE SIGNED: 6-16-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 18, 1960

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or county) (State): Bel Air, Harford Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster
ADDRESS: W. Broadway + Williams St. Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 20 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06941

6968

# CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: 354 Carter St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jesse — Middle B. — Last Clifton

4. DATE OF DEATH: Month June — Day 24th — Year 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 16, 1890

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machisist. U.S. Govt.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel Clifton Deceased

14. MOTHER'S MAIDEN NAME: Unknown. Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 226-05-1633

17. INFORMANT: Ivey Clifton - wife — Address: same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Bronchial Asthma
DUE TO (c): Cor Pulmonale

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 1958 to June 24 1960, that (I) (we) last saw the deceased alive on June 24 1960 and that death occurred at ___ PM, from the causes and on the date stated above.

22a. SIGNATURE: John L. Wachsman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/24/60

22c. PHYSICIAN'S NAME (Type): Irvin Wachsman, M.D.

22d. ADDRESS: 407 S. Union Ave. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/27/60

23c. NAME OF CEMETERY OR CREMATORY: Bakers Cemetery

23d. LOCATION (City, town, or county) (State): RD. Aberdeen, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen, Md.

John G. Tarring

25a. REC'D BY REGISTRAR DATE: JUN 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06942

6969

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: HARford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Havre de Grace
d. STREET ADDRESS: 331 N. Union Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theresa — Middle: Rae — Last: DeLP

4. DATE OF DEATH: Month: June — Day: 22 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1960

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: 2 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Olan Ray DeLP

14. MOTHER'S MAIDEN NAME: Alice Ernestine Ashby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Olan R. DeLp — Address: 331 N. Union Ave. Hvre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial Hemorrhage (Subarachnoid) — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Prematurity
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 760.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Premature labor.

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 20 1960, to June 22 1960 that (I) (we) last saw the deceased alive on June 22 1960 and that death occurred at 11:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: William M. Leen M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/22/60

22c. PHYSICIAN'S NAME (Type): William M. LEEN

22d. ADDRESS: 600 S. Union Ave. Havre de Grace Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal.

23b. DATE THEREOF: 6/23/60

23c. NAME OF CEMETERY OR CREMATORY: Huffman Family Cemetery

23d. LOCATION (City, town, or county) (State): Princeton, R.D.#1 - W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring

ADDRESS: Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: JUN 27 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kime

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

20712624V1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6970

# CERTIFICATE OF DEATH

06943

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 3½ hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hartford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit. 07X-2
d. STREET ADDRESS: Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carl — Middle: E. — Last: Goodman.

4. DATE OF DEATH: Month: 6 — Day: 10 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 6, 1900

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber.

10b. KIND OF BUSINESS OR INDUSTRY: Barber Shop

11. BIRTHPLACE (State or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard H. Goodman

14. MOTHER'S MAIDEN NAME: Dora Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. War II

16. SOCIAL SECURITY NO.: 216-20-2276

17. INFORMANT: Elmer Reedy — Address: Port Deposit, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO (b):
DUE TO (c):
420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour: o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-10 1960 to 6-10 1960, that (I) (we) last saw the deceased alive on 6/8 1960, and that death occurred at 3:20 P. M., from the causes and on the date stated above.

22a. SIGNATURE: G.H. Richards Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/11/60

22c. PHYSICIAN'S NAME (Type): G.H.Richards Jr. M.D.

22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-13-1960

23c. NAME OF CEMETERY OR CREMATORY: Conowingo Baptist

23d. LOCATION (City, town, or county) (State): Conowingo, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Vera Patterson & Son — ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: JUN 14 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

M

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06944

1. PLACE OF DEATH — 6971
a. COUNTY: HARFORD
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewood Rural,
d. STREET ADDRESS: Box 622 (Van Bibber)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: VIRGIE Middle: M. Last: HARRIS
4. DATE OF DEATH: Month: 6 Day: 1 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 25, 1909
9. AGE (In years last birthday): 50 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gas Mask Assembler
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.,
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.,
13. FATHER'S NAME: Melvin Tiller
14. MOTHER'S MAIDEN NAME: Nora Mc Fadden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or detes of service): no
16. SOCIAL SECURITY NO.: 213-16-9314
17. INFORMANT: Luther Harris Address: Edgewood, R.D., Md.,

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushing injury of chest.
816X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Auto-auto accident
20c. TIME OF INJURY: Hour 1:15 a.m. p.m. Month, Day, Year: 6/1/1960
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): Edgewood (County): Harford (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm. Smith M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Address (Street, city, town, or county):
DATE SIGNED: June 2, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June, 5, 1960
22c. NAME OF CEMETERY OR CREMATORY: Cokesbury Memorial
22d. LOCATION (City, town, or country) (State): Abingdon, Harford, Md.,

23. FUNERAL DIRECTOR: Howard K. McComas Jr. ADDRESS: Abingdon, Md.,
24a. REC'D BY REGISTRAR DATE JUN 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

6960 06945

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Front St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Blaine — Middle: G — Last: Hartenstine

4. DATE OF DEATH: Month: June — Day: 17 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 25, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad employee

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Peter Hartenstine

14. MOTHER'S MAIDEN NAME: Sarah R. Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Melvin Hartenstine, Perryville, Md.
Address

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Coma, terminating — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
DUE TO
(b): — INTERVAL: —
DUE TO
(c): Chronic cirrhosis of the liver — INTERVAL: 1 year

581.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic bronchial asthma; Chronic cardio-vascular disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 30, 1959 to June 17, 1960, that (I) (we) last saw the deceased alive on June 17, 1960, and that death occurred at 7:25 PM from the causes and on the date stated above.

22a. SIGNATURE: Willard P. Hudson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 17, 1960

22c. PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22d. ADDRESS: Forest Hill, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-19-1960
23c. NAME OF CEMETERY OR CREMATORY: Principio Cemetery
23d. LOCATION (City, town, or county) (State): Principio Furnace, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Vera Patterson & Son
ADDRESS: Perryville, Md

25a. REC'D BY REGISTRAR
DATE JUN 20 '60

25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6972

06947

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Forrest Hill Bel Air Md
d. STREET ADDRESS Forrest Hill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Carl Middle Henry Last Henderson.

4. DATE OF DEATH Month 6 Day 10 Year 1960

5. SEX Male
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH ?
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY Unknown
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charlie Henderson.
14. MOTHER'S MAIDEN NAME Alice —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Mrs Mack Dixon Address Prospect Mills Rd. Bel Air

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH 16 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Asthma
DUE TO (c) Emphysema
527.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 28 1960, to June 10, 1960 that (I) (we) last saw the deceased alive on June 10 1960, and that death occurred at 6.25 P.M., from the causes and on the date stated above.

22a. SIGNATURE E. J. Simon M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 6-10-60
22c. PHYSICIAN'S NAME (Type) E. J. SIMON
22d. ADDRESS Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 6/14/60
23c. NAME OF CEMETERY OR CREMATORY REEDY
23d. LOCATION (City, town, or county) RUGBY (State) Va.

24. FUNERAL DIRECTOR'S SIGNATURE Tommy Lee Ben ADDRESS Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE JUN 14 '60
25b. REGISTRAR'S SIGNATURE Clifton E. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06948

Reg. Dist. No.

6961 Item 7 Film G26 6-20-60 et

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fenford Ave

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: H
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18 3V01.4
d. STREET ADDRESS: 2726 Tivoly Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mark Middle Spangler Last Hudson Sr
4. DATE OF DEATH: Month June Day 11 Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-20-10
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Worker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greenwell W. Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wilbur H Hudson
14. MOTHER'S MAIDEN NAME: Myrtle May Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Reba Ann Hudson 2726 Tivoly Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
8197

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident auto-object type
20c. TIME OF INJURY: Hour 7:45 o. m. Month, Day, Year 6-11 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Fenford Ave
20f. (City or town) Bel Air (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — Bel Air, Md — DATE SIGNED: 6-11-60
EXAMINER'S NAME (Type): Gerald C Palmer MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/15/60
22c. NAME OF CEMETERY OR CREMATORY: Sunset Cem
22d. LOCATION (City, town, or county) (State): Beckley W Va

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Leonard J. Ruck Inc 5305 Harford Rd
24a. REC'D BY REGISTRAR DATE: JUN 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66949

6973

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVER DE GRACE
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 HAVER DE GRACE
d. STREET ADDRESS: 80 WAKEFIELD DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First AMY — Middle ADELAIDE — Last DECKMAN JAMISON

4. DATE OF DEATH: Month 6 — Day 7 — Year 1960

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 5/22/1879

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WAKEMAN JOURDAN

14. MOTHER'S MAIDEN NAME: MARY M. MITCHELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mrs. CONNIE BAKER — Address: SAME AS ABOVE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro vascular accident
DUE TO
(b): cerebral arteriosclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 days / 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 19 58 to 6/7 19 60, that I last saw the deceased alive on 6/5 19 60, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md — DATE SIGNED: 6/7/60

PHYSICIAN'S NAME (Type): Neil Taylor Jr M.D. Rising Sun, Md. 6/7/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 6/10/1960

22c. NAME OF CEMETERY OR CREMATORY: ROCK RUN CEM.

22d. LOCATION (City, town, or county): DARLINGTON, (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen — ADDRESS: RISING SUN, MD.

24a. REC'D BY REGISTRAR — DATE: JUN 9 '60

24b. REGISTRAR'S SIGNATURE: Charles J. Kerr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06950

6962

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18 — 3V01.4

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Fulford Acre

d. STREET ADDRESS: 3910 S Clair Rd

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cecil — Middle: R — Last: Jones

4. DATE OF DEATH: Month: June — Day: 11 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 30 1910

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Industry

11. BIRTHPLACE (State or foreign country): Raleigh, W. Va

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alphons Jones

14. MOTHER'S MAIDEN NAME: Hattie Woods

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Alice Jean Jones 3910 S Clair Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

8197

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Auto accident auto - object tyre

20c. TIME OF INJURY: Hour 730 o. m. p. m. — Month, Day, Year: 6-11 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Fulford Ave

20f. (City or town) Bel Air (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF M.D.: Gerald C Palmer — CHIEF MEDICAL EXAMINER ☐ — Bel Air Md — DATE SIGNED

EXAMINER'S NAME (Type): Gerald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — 6-11-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/14/60

22c. NAME OF CEMETERY OR CREMATORY: Prosperity Cem.

22d. LOCATION (City, town, or county) (State): Berkley W. Va

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leonard J. Rick Inc 305 Hartford Rd

24a. REC'D BY REGISTRAR DATE: JUN 15 60

24b. REGISTRAR'S SIGNATURE: Anna L. Turner

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22c FilmG26 6-21-60 et

06951

## CERTIFICATE OF DEATH

6963

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air
c. LENGTH OF STAY IN 1b Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 127 Alice Anne Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air
d. STREET ADDRESS 127 Alice Anne Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First NATHAN Middle A. Last KELL

4. DATE OF DEATH Month JUNE Day 15, Year 1960

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Feb. 22, 1893

9. AGE (In years last birthday) 67 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter

10b. KIND OF BUSINESS OR INDUSTRY Restaurant

11. BIRTHPLACE (State or foreign country) Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Kell

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO. 214-12-3763

17. INFORMANT Josephine Clark Address 115 Bond Street Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 12 hrs

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 60, to June 15, 1960, that I last saw the deceased alive on June 15, 1960, and that death occurred at 8 24 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Charles Richardson Jr M.D. — ADDRESS (Street, city or town, state) Bel Air, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF June 18, 1960

22c. NAME OF CEMETERY OR CREMATORY Fair View Methodist Cem Clark's Chapel Cemetery

22d. LOCATION (City, town, or county) (State) Bel Air Rural, Harford Co, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster — ADDRESS W. Broadway & Williams St. Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE JUN 17 '60

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6974 **CERTIFICATE OF DEATH** 06952

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — STATE: Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 24
d. STREET ADDRESS: 724 Erie 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: — Last: Langevin
4. DATE OF DEATH: Month: 6 — Day: 11 — Year: 60 19
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/19/1885
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Comiti
14. MOTHER'S MAIDEN NAME: Ida Poltretti
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Rose Langevin — Address: 724 Erie St. Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Pulmonary Oedema | 5 Minutes |
| DUE TO (b) | Coronary occlusion | 1 Hour |
| DUE TO (c) | Chronic Myocarditis | 10 years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1956, to June, 1960, that I last saw the deceased alive on June 11, 1960, and that death occurred at 2:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Wolbert M.D. — ADDRESS (Street, city or town, state): 200 North Union Ave — DATE SIGNED: 6/12/60

PHYSICIAN'S NAME (Type): FRANK WOLBERT MD — Havre de Grace Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 6/15/60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Erin
22d. LOCATION (City, town, or county) (State): Havre de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE: Langevin & Son — ADDRESS: Havre de Grace Md
24a. REC'D BY REGISTRAR DATE JUN 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1.

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6959 Items 7,12 FilmG265 6-17-60 et

06953 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Penna. R.R. Tracks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Aberdeen (Rural)
d. STREET ADDRESS: R.D. #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wasil; Middle: Unknown; Last: Meluk
4. DATE OF DEATH: Month: June; Day: 9; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): Appr. 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Canning Industry
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Unknown ?
14. MOTHER'S MAIDEN NAME: Unknown ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.-1
16. SOCIAL SECURITY NO.: 215-05-8204
17. INFORMANT: Chas. B. Osborn Jr. Address: R.D. 3 Aberdeen, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Complete Body dismemberment — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
DUE TO (c):

802 ✓

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Walked across R.R. tracks & Train struck him.
20c. TIME OF INJURY: Hour: 10:00 a. m.; Month, Day, Year: 6-9 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Penna R.R Tracks
20f. (City or town): Aberdeen (County): Harford (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Baltimore, Md
DATE SIGNED: 6-9-60
EXAMINER'S NAME (Type): Gerald C. Palmer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/11/60
22c. NAME OF CEMETERY OR CREMATORY: Bakers Cemetery
22d. LOCATION (City, town, or county) (State): R.D. Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
ADDRESS: Tarring Funeral Home Aberdeen, Md.
John G. Tarring
24a. REC'D BY REGISTRAR DATE: JUN 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06954

Reg. Dist. No. 6989

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JOPPA
c. LENGTH OF STAY IN 1b: 9 MOS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 750A ALEXIS DR., RD#2 JOPPA, Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JOPPA
d. STREET ADDRESS: Box 750A ALEXIS DR. RD#2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roy — Middle: LOCKWOOD — Last: MILLER
4. DATE OF DEATH: Month: JUNE — Day: 22 — Year: 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 24 1919
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MILLWRIGHT
10b. KIND OF BUSINESS OR INDUSTRY: AUTOMOTIVE
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: LUTHER CARL MILLER
14. MOTHER'S MAIDEN NAME: MARGARET MARIE GRIMES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 168-09-5350
17. INFORMANT: TOM MILLER — Address: 4 QUINCE LANE BALTIMORE 20, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 10 MIN
420.1
DUE TO (b): CORONARY INSUFFICIENCY — ABOUT 3 WKS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Heuman M.D.
EXAMINER'S NAME (Type): PHILIP W. HEUMAN, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JUNE 22, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: June 26, 1960
22c. NAME OF CEMETERY OR CREMATORY: Lloyd
22d. LOCATION (City, town, or county) (State): Ebensburg, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: LASSAHN FUNERAL HOME, BALTIMORE, MD — ADDRESS
24a. REC'D BY REGISTRAR DATE: JUN 24 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6975 **CERTIFICATE OF DEATH** 06955

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Harford.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen.
d. STREET ADDRESS 1 Monroe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mary Middle L. Last Moore

4. DATE OF DEATH Month 6 Day 2 Year 1960

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 29, 1931
9. AGE (In years last birthday) 29 yrs.
IF UNDER 1 YEAR Months 2 Days 4
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jack Cottman.
14. MOTHER'S MAIDEN NAME Martha Woodley.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 213-26-6414
INFORMANT Mrs. Martha J. Cottman, Address 3 Moffat St. Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Yellow Atrophy Liver — INTERVAL BETWEEN ONSET AND DEATH 2 weeks
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
580X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factary, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/28/, 1960, to 6/3/, 1960, that I last saw the deceased alive an 6/2/, 1960, and that death accurred at M, from the causes and an the date stated abave.

ACTUAL SIGNATURE Irvin L. Wachsman M.D. ADDRESS (Street, city or town, stote) Havre de Grace, Md DATE SIGNED 6/3/60

PHYSICIAN'S NAME (Type) Irvin L. Wachsman, M.D. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal
22b. DATE THEREOF 6/6/60
22c. NAME OF CEMETERY OR CREMATORY Little Mount Baptist
22d. LOCATION (City, town, or county) (Stote) Sussex County, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock ADDRESS Havre de Grace, Md
24a. REC'D BY REGISTRAR DATE JUN 7 '60
24b. REGISTRAR'S SIGNATURE Clarence L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Item 20 Film 265 6-28-60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06956

1 FOR STATE HEALTH DEPT.

6990

Phone Call - Med. Ex. Office - 6-17-60 - MS

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Brought ashore on the beach at)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania (Baltimore) b. COUNTY: Chester (Harford)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Delair) West Chester 75X-3
d. STREET ADDRESS: R.F.D. #4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle S. — Last MORRIS
4. DATE OF DEATH: Month June — Day 16 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 14, 1906
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Eng.
10b. KIND OF BUSINESS OR INDUSTRY: Lukens Steel Co-Pa
11. BIRTHPLACE (State or foreign country): Oxford N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph A. Morris
14. MOTHER'S MAIDEN NAME: Lizzie Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Jessie Bird Day Morris — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH

850X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): Fell overboard from a runabout boat

20c. TIME OF INJURY Hour a.m. Month, Day, Year: 6/11/60 8:00 PM
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): North East River
20f. (City or town): — (County): Harford — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm. Yeatts M.D.
EXAMINER'S NAME (Type):
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
DATE SIGNED: June 16, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 6/17/60
22c. NAME OF CEMETERY OR CREMATORY: Marshalltown Methodist
22d. LOCATION (City, town, or country): Marshalltown — (County): Chester Co. — (State): Pa.

23. FUNERAL DIRECTOR: Wm J. Tickner & Sons
ADDRESS: Belto. Md.
24a. REC'D BY REGISTRAR DATE: JUN 20 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6991 — Reg. Dist. No. 06957

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
c. LENGTH OF STAY IN 1b: 6 mos.,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Francis Bar

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Abingdon
d. STREET ADDRESS: Francis Bar
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Goldie — Middle: E — Last: Nichols

4. DATE OF DEATH: Month: June — Day: 14 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1912

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Tavern

11. BIRTHPLACE (State or foreign country): W.Va.,

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Herman W. Neeley

14. MOTHER'S MAIDEN NAME: Tressie K. Marion

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 235-28-6004

17. INFORMANT: L.S. Neeley, — Address: Elkview W.Va.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 2SW chest — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self with pistol

20c. TIME OF INJURY: Hour: 12½ a.m. p.m. — Month, Day, Year: 6-14 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Francis Bar

20f. (City or town): Abingdon (County): Ha (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — DATE SIGNED: 6-14-60

EXAMINER'S NAME (Type): Gerald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ Boaz Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: June 15, 1960
22c. NAME OF CEMETERY OR CREMATORY: Hafer Funeral Home
22d. LOCATION (City, town, or county) (State): Elkview, Kanawha, W.Va.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. Mc Comas Jr. — ADDRESS: Abingdon, Md.,

24a. REC'D BY REGISTRAR DATE: JUN 17 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

6992

Reg. Dist. No. 06958

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Stafford Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Darlington
d. STREET ADDRESS: 1 Stafford Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Sarah Middle: a Last: Pardew

4. DATE OF DEATH: Month: June Day: 9 Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 8/17/1876

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Allegheny Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henderson Sheets

14. MOTHER'S MAIDEN NAME: Millie Hagans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Amory Pardew — Address: Darlington Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cvdisease
DUE TO
(b):
DUE TO
(c):

422-1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-1, 1960 to 6-9, 1960, that I last saw the deceased alive on 6-6, 1960, and that death occurred at 4P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald C Palmer M.D.
ADDRESS (Street, city or town, state): Dallastown, md
DATE SIGNED: 6-11-60

PHYSICIAN'S NAME (Type): Gerald C Palmer MD

22a. BURIAL, CREMATION, REMOVAL (Specify): June 13 1960
22b. DATE THEREOF:
22c. NAME OF CEMETERY OR CREMATORY: Darlington Cem.
22d. LOCATION (City, town, or county): Harford Co. (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. E. Bailey
ADDRESS: Darlington, Md

24a. REC'D BY REGISTRAR DATE: JUN 15 '60

24b. REGISTRAR'S SIGNATURE: Carlton S. Powell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6993

# CERTIFICATE OF DEATH

06959

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Havre de Grace
d. STREET ADDRESS: 801 So. Wash. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY — Middle Jones — Last REASIN

4. DATE OF DEATH: Month June — Day 17 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/23/1891

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR — Months — Days
IF UNDER 24 HRS. — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GRACE FOREMAN US Govt
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (State or foreign country): HAVRE de GRACE Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALFRED REASIN
14. MOTHER'S MAIDEN NAME: REBECCA TOWNSLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS HARRY REASIN — Address: 801 S WASHINGTON

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1dy
DUE TO (b): Coronary arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/12 19__ to 6/17 1960 that (I) (we) last saw the deceased alive on 6/17 1960 and that death occurred at 9:45 AM. from the causes and on the date stated above.

22a. SIGNATURE: Thom h. Wadsworth, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/20/1960
23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL
23d. LOCATION (City, town, or county) (State): HAVRE de GRACE Md

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace Md.
25a. REC'D BY REGISTRAR DATE: JUN 21 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kroma

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

6994

06960 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 100 Pusey Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 100 Pusey Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MALISSA Middle M. Last RICHARDSON

4. DATE OF DEATH: Month June Day 27 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 17, 1898
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jesse E. McMillan
14. MOTHER'S MAIDEN NAME: Fannie Dixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-20-4036
17. INFORMANT: Harry L. Richardson, Havre de Grace, Md. Address 100 Pusey St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolesin — INTERVAL BETWEEN ONSET AND DEATH: 1 dy
420.0
DUE TO (b): Mural cardiac Thrombosis — 1 week
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost.
DUE TO (c): Arteriosclerotic Heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial asthma
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1957 to 27 June, 1960, that I last saw the deceased alive on June 27, 1960, and that death occurred at 11:30 AM, from the causes and on the date stated abave.

ACTUAL SIGNATURE: Irvin L. Wachsman M.D.
ADDRESS (Street, city or town, state): 407 S. Union Ave.
DATE SIGNED: 6/28/60

PHYSICIAN'S NAME (Type): Irvin Wachsman, M.D. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/2/60
22c. NAME OF CEMETERY OR CREMATORY: Center Cemetery
22d. LOCATION (City, town, or county) (State): Nathans Creek, N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
ADDRESS: Tarring Funeral Home, Aberdeen, Md.
John G. Tarring

24a. REC'D BY REGISTRAR DATE: JUN 30 '60
24b. REGISTRAR'S SIGNATURE: Catherine L. Travers

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

6995

06961 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) JARRETTSVILLE
c. LENGTH OF STAY IN 1b: 12YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RD#1 ROCKS, Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) JARRETTSVILLE
d. STREET ADDRESS: RD#1 ROCKS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA Middle ELLEN Last RICHARDSON

4. DATE OF DEATH: Month JUNE Day 1 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 17, 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN ABSHER

14. MOTHER'S MAIDEN NAME: MARGARET WAGONER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 223-12-2674

17. INFORMANT: MARGARET RICHARDSON EVERETT Address: ROCKS, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA, LOBAR — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO
(b): LEFT HEMIPLEGIA, PARTIAL — 2 WKS
DUE TO
(c):

352X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 23, 1960, to MAY 31, 1960 that I last saw the deceased alive on MAY 31, 1960, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip W. Heuman M.D. ADDRESS (Street, city or town, state): 307 HICKORY DATE SIGNED: JUNE 4 1960

PHYSICIAN'S NAME (Type): PHILIP W. HEUMAN BEL AIR, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/3/1960
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz ADDRESS: Jarrettsville Md

24a. REC'D BY REGISTRAR DATE: JUN 3 '60

24b. REGISTRAR'S SIGNATURE: Clifford S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6975 06962

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford (Recd)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural 07X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Baby Middle: Boy Last: Rierson

4. DATE OF DEATH: Month: June Day: 5 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 5, 1960

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours 2 Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Rierson

14. MOTHER'S MAIDEN NAME: Nancy Delp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: William Rierson Address: Rising Sun, Md

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hydrocephalus
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Orlando L. Marinelli M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 6/6/1960

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/8/1960

23c. NAME OF CEMETERY OR CREMATORY: Nottingham Cemetery

23d. LOCATION (City, town, or county) (State): Colora Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen ADDRESS: Rising Sun, Md.

25a. REC'D BY REGISTRAR DATE: JUN 9 '60

25b. REGISTRAR'S SIGNATURE: Cristina S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

2071181X45

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

6977

Reg. Dist. No. 06963

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Aberdeen (Rural)
d. STREET ADDRESS: R.D. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS — Middle C — Last SCHANTZ

4. DATE OF DEATH: Month June — Day 6 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 9, 1899

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shop Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Auto Garage

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John George Schantz

14. MOTHER'S MAIDEN NAME: May F. Reauter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-03-2962

17. INFORMANT: Helen M. Schantz, Address R.D. #2 Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 June, 1960, to 6 June, 1960, that I last saw the deceased alive on 6 June, 1960, and that death occurred at 12:01 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas Richardson Jr. M.D.
ADDRESS (Street, city or town, state): Bel Air, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Charles Richardson Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/9/60
22c. NAME OF CEMETERY OR CREMATORY: Bakers Cemetery
22d. LOCATION (City, town, or county) (State): R.D. 2, Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
ADDRESS: Tarring Funeral Home Aberdeen, Md.
John G. Tarring

24a. REC'D BY REGISTRAR DATE: JUN 10 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

6978

Reg. Dist. No. 06964

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE-DE-GRACE
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RISING SUN — RURAL
d. STREET ADDRESS: 07X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAULINE — Middle — Last SHMEL

4. DATE OF DEATH: Month JUNE — Day 30 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 18, 1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL DEMICK

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MICHAEL SHMEL — Address: RISING SUN, MD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO (b): Arteriosclerotic heart disease — 8 years

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420 20

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 6/10, 1960, to 6/30, 1960, that I last saw the deceased alive on 6/30, 1960, and that death occurred at 7P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor — M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md — DATE SIGNED: 7/1/60

PHYSICIAN'S NAME (Type): Neil Taylor Jr — Rising Sun, Md — 7/1/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JULY 3, 1960

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEM.

22d. LOCATION (City, town, or county) (State): HARTFORD CONN.

23. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen — ADDRESS: Rising Sun Md

24a. REC'D BY REGISTRAR DATE: JUL 5 60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6979 CERTIFICATE OF DEATH

Reg. Dist. No. 06965

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: about 34 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 653 St. Clair St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): 24 Havre de Grace
d. STREET ADDRESS: 653 St. Clair St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah Middle: E. Last: Smith

4. DATE OF DEATH: Month: 6 Day: 14 Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-23-1909

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beautician

10b. KIND OF BUSINESS OR INDUSTRY: Beauty Culture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George H. Hoke

14. MOTHER'S MAIDEN NAME: Mazie Kell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-32-4130

INFORMANT: Mrs. Margaret Hoke, Address 511 Pink Street, Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Day of Death

420.1

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse lost.
DUE TO (b): —
DUE TO (c): Hypertensive-Arteriosclerotic Heart disease — 6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1960, to June 14, 1960, that I last saw the deceased alive an June 14, 1960, and that death accurred at 5:45 P M, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: George T. Stansbury, M.D. — ADDRESS (Street, city or town, state): 569 Revolution Street — DATE SIGNED: 6/15/60

PHYSICIAN'S NAME (Type): George T. Stansbury — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-18-1960

22c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cem.

22d. LOCATION (City, town, or county) (State): Aberdeen, Harford Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Otelia J. Bullock, Havre de Grace, Md. — ADDRESS: 556 Lewis St.

24a. REC'D BY REGISTRAR — DATE: JUN 17 '60

24b. REGISTRAR'S SIGNATURE: Ardelia S. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6980

# CERTIFICATE OF DEATH

06966

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE

c. LENGTH OF STAY IN 1b: 6 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RD 1 WHITEFORD

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HARRY — Middle J. — Last SMITHSON

4. DATE OF DEATH: Month JUNE — Day 5 — Year 1960

5. SEX: M.

6. COLOR OR RACE: WH.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 1/23/00

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: SLATE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES SMITHSON

14. MOTHER'S MAIDEN NAME: OLIVIA SMITHSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 184-05-1577

INFORMANT: Eliz. R. Jones — Address: (SAME AS ABOVE)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pericarditis etiology unknown.
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus Cardiac Decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/31, 1960, to 6/5, 1960, that I last saw the deceased alive on 6/5, 1960, and that death occurred at 12:45 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Khalatbari M.D. — ADDRESS (Street, city or town, state): HARFORD MEM. HOSP. — DATE SIGNED: 6/5/60

PHYSICIAN'S NAME (Type): W. K. BRENDLE / J. KHALATBARI — HAVRE DE GRACE MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 6-8-60

22c. NAME OF CEMETERY OR CREMATORY: SLATE RIDGE

22d. LOCATION (City, town, or county) (State): DELTA, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbine — ADDRESS: Delta, Pa.

24a. REC'D BY REGISTRAR DATE: JUN 8 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

6981 06967

1. PLACE OF DEATH
a. COUNTY: HARFORD
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace Md.
d. STREET ADDRESS: 516 N. Adams
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WARNER Middle C. Last TAYLOR

4. DATE OF DEATH: Month JUNE Day 27 Year 1960

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 25 1873
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boat Builder
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: GEORGE WARNER B. TAYLOR
14. MOTHER'S MAIDEN NAME: MARY Ann Hagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mell A. Taylor Address: 516 N. Adams Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): /ZZX
DUE TO (b): Ca. of prostate
DUE TO (c): ____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH
(a) 1 month
(b) 1 year
(c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 17th 1960 to June 27th 1960 that (I) (we) last saw the deceased alive on June 27 1960 and that death occurred at 5:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/27/60
22c. PHYSICIAN'S NAME (Type): EDWARD C. LOO, M.D.
22d. ADDRESS: 211 N. Union Ave. Havre de Grace Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/30/60
23c. NAME OF CEMETERY OR CREMATORY: Elkton
23d. LOCATION (City, town, or county) (State): Elkton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lemmon Bros.
ADDRESS: Havre de Grace Md.
25a. REC'D BY REGISTRAR DATE JUL 1 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06968

Reg. Dist. No.

6982

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: PC
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington — 47X-3
d. STREET ADDRESS: 950 Mississippi Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Melvin — Middle: — Last: Walton
4. DATE OF DEATH: Month: June — Day: 10 — Year: 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 14, 1920
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MUSICIAN
10b. KIND OF BUSINESS OR INDUSTRY: ENTERTAINMENT
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY WARSHAWSKY
14. MOTHER'S MAIDEN NAME: ROSE LOSIKOFF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 133-07-9714
17. INFORMANT: SIDNEY RAPKE — Address: 6304 E. HALBERT RD. BETHESDA Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushing injury Chest — INTERVAL BETWEEN ONSET AND DEATH: —

816X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident auto auto type

20c. TIME OF INJURY: Hour: 1:20 p.m. — Month, Day, Year: 6-10 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State):

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer — M.D.
CHIEF MEDICAL EXAMINER ☐ BB Ave, Md
EXAMINER'S NAME (Type): Gerald C Palmer, M.D.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-10-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JUNE 12, 1960
22c. NAME OF CEMETERY OR CREMATORY: KING DAVID MEMORIAL GARDEN
22d. LOCATION (City, town, or county) (State): FALLS CHURCH Va.

23. FUNERAL DIRECTOR'S SIGNATURE: B Benjamin Sons
ADDRESS: 3501-14 M. Ave
24a. REC'D BY REGISTRAR — DATE: JUN 14 '60
24b. REGISTRAR'S SIGNATURE: Orlin S. Kuhn

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6983

# CERTIFICATE OF DEATH

06963

1. **PLACE OF DEATH** a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 14 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 HAVRE DE GRACE
d. STREET ADDRESS: 108 WILSON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: EARL Middle: EMANUEL Last: WEAVER

4. **DATE OF DEATH**: Month: JUNE Day: 27 Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/14/03

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISABLED

10b. KIND OF BUSINESS OR INDUSTRY: Painter

11. BIRTHPLACE (State or foreign country): PENN.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel M. Weaver

14. MOTHER'S MAIDEN NAME: Alberta Rugel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): W.W. 2

16. SOCIAL SECURITY NO.: Unknown

17. **INFORMANT**: BETTY J. WEAVER Address: SAME.

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pulmonary edema | 1 dy |
| DUE TO (b) | Coronary Occlusion | 1 dy |
| DUE TO (c) | Myocardial infarction | 1 dy |

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1, 1958 to June 27, 1960, that (I) (we) last saw the deceased alive on June 27, 1960, and that death occurred at 12:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John h. Wachsman M.D.

22b. DATE SIGNED: 6/27/60

22c. PHYSICIAN'S NAME (Type): IRVIN N. WACHSMAN

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 6/30/60

23c. NAME OF CEMETERY OR CREMATORY: Hoffman

23d. LOCATION (City, town, or county) (State): Near Danbury Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Emanuel Jr, Havre de Grace, Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE: JUN 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kline

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6984 Reg. Dist. No. 06970

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) × Havre de Grace
d. STREET ADDRESS RD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Dra Middle E Last Wilkinson
4. DATE OF DEATH Month June Day 21 Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 19 1898
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Foreman
10b. KIND OF BUSINESS OR INDUSTRY Chordey Brown Trucking
11. BIRTHPLACE (State or foreign country) Harford Co, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter Wilkinson
14. MOTHER'S MAIDEN NAME Ida Carr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-01-6545
17. INFORMANT Mrs Dra Wilkinson Address 2 Hours Use Grace Md Rural

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH —
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Gerald C Palmer M.D. Bel Air Md DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Gerald C Palmer M.D. DEPUTY MEDICAL EXAMINER ☒ 6-22-60

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF June 25, 1960
22c. NAME OF CEMETERY OR CREMATORY Hosly an Chapel
22d. LOCATION (City, town, or county) (State) Harford Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE H S Bailey ADDRESS Darlington Md
24a. REC'D BY REGISTRAR DATE JUN 28 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6985

## CERTIFICATE OF DEATH

06971

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 days + 12 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit — 07x-2
d. STREET ADDRESS: 49 So. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Pauline — Middle: — Last: Will

4. DATE OF DEATH: Month: June — Day: 22 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-12-1888

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: ? Brauer

14. MOTHER'S MAIDEN NAME: — Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-34-0563

17. INFORMANT: Muriel Jackson — Address: Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
DUE TO (b): Hypertensive Cardio Vascular disease — 10 yrs.
DUE TO (c):

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 19 46, to June 22, 1960, that (I) (we) last saw the deceased alive on June 22, 1960, and that death occurred at 10:12 M, from the causes and on the date stated above.

22a. SIGNATURE: G.H. Richards Jr. M.D. — M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): G.H. Richards Jr. M.D.

22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-24-1960

23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.

23d. LOCATION (City, town, or county) (State): Colora, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson & Son — ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR: DATE: JUN 24 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

6964

Reg. Dist. No. 06972

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air,
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cora — Middle: Isabelle — Last: Williams

4. DATE OF DEATH: Month: June — Day: 9 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 14, 1868

9. AGE (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harvey Pennington

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Arthur C Ashley — Address: Bel Air

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Chronic Cardio-vascular disease — ?
DUE TO (c):

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1950, to June, 1960 that I last saw the deceased alive on June 9, 1960, and that death occurred at 8:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Willard P. Hudson M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: June 10, 1960

22c. NAME OF CEMETERY OR CREMATORY: Smith Lot M. C

22d. LOCATION (City, town, or county) (State): M. C.

23. FUNERAL DIRECTOR'S SIGNATURE: H & S Bailey — ADDRESS: Harlington, Md.

24a. REC'D BY REGISTRAR DATE: JUN 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

6996

Reg. Dist. No. 06973

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lida — Middle: M. — Last: Willis

4. DATE OF DEATH: Month: June, — Day: 27 — Year: 19 60

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar.9, 1882

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Churchville, Md.,

12. CITIZEN OF WHAT COUNTRY? U.S.A.,

13. FATHER'S NAME: William A. Bodt

14. MOTHER'S MAIDEN NAME: Annie Preston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Levering O. Willis — Address: Abingdon Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gangrene left lower leg — INTERVAL BETWEEN ONSET AND DEATH: 1 month.
DUE TO (b): Arteral Sclerosis - hemeplegia — 2 years 2 months
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4501

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 15, 1960, to June 27, 1960, that I last saw the deceased alive on June 27, 1960, and that death occurred at 7.45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred O Hodus M.D. — ADDRESS (Street, city or town, state): Edgewood Maryland. — DATE SIGNED

PHYSICIAN'S NAME (Type): Fred O. Hodus — Edgewood Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June, 30, 1960

22c. NAME OF CEMETERY OR CREMATORY: Smith's Chapel

22d. LOCATION (City, town, or county) (State): Churchville Harford Md.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K McComas Jr — ADDRESS: Abingdon, Md.

24a. REC'D BY REGISTRAR DATE: JUL 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kinard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6986

## CERTIFICATE OF DEATH

06974

1. **PLACE OF DEATH** a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Delaware — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington 46x-3
d. STREET ADDRESS: 300 E. 25th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Gabrella — Middle: — Last: Winn

4. **DATE OF DEATH**: Month: June — Day: 25, — Year: 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 12, 1877
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bayview, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Ray
14. MOTHER'S MAIDEN NAME: Hester Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. **INFORMANT**: Mr. Robert C. Winn, Jr. — Address: Rt. #40 Havre de Grace, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Insufficiency
DUE TO (b): Cardiac Vascular disease
DUE TO (c): Chronic Diffuse Nephritis

592x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-6 1960 to 6-27 1960, that (I) (we) last saw the deceased alive on June 24 1960, and that death occurred at 1255 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/26/60
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 28, 1960
23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Baptist Cem.
23d. LOCATION (City, town, or county) (State): North East Cecil Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Elmer E. Bullock — ADDRESS: 556 Lewis St. Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE: JUN 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6997 06975

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): White Hall
c. LENGTH OF STAY IN 1b: 34 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RD

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Hall
d. STREET ADDRESS: RD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: Yingling — Last: Wright
4. DATE OF DEATH: Month: June — Day: 28 — Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7-22-1888
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM
11. BIRTHPLACE (State or foreign country): HARFORD Co., MD
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: WILLIAM A. WRIGHT
14. MOTHER'S MAIDEN NAME: R. VIRGINIA BULL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 219-36-0459
17. INFORMANT: Wm K Wright — Address: Pylesville RD, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Arteriosclerotic CV disease — INTERVAL BETWEEN ONSET AND DEATH: ~
422.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER [ ] Belair, Md
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
Address (Street, city, town, or county)
DATE SIGNED: 6-28-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-30-60
22c. NAME OF CEMETERY OR CREMATORY: ST. PAUL METH.
22d. LOCATION (City, town, or country) (State): NORRISVILLE, HARFORD Co., MD.

23. FUNERAL DIRECTOR: Kenneth Cochran — ADDRESS: Stewartstown Penna.
24a. REC'D BY REGISTRAR DATE: JUN 30 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO DEATH MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible]. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59